SENATE COMMITTEE ON HEALTH
Senator Dr. Susan Talamantes Eggman, Chair

BILL NO: SB 90
AUTHOR: Wiener
VERSION: March 21, 2023
HEARING DATE: April 26, 2023
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: insulin affordability

SUMMARY: Prohibits a health plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 2024, from imposing a copayment on an insulin prescription drug that exceeds $35 for a 30-day supply, and from imposing a deductible, coinsurance, or any other cost-sharing on an insulin prescription drug, as specified.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers. [HSC §1340, et seq., and INS §106, et seq.]

2) Establishes the Kaiser Small Group Health Maintenance Organization (HMO) as California's essential health benefits (EHBs) benchmark under the Affordable Care Act (ACA), California health insurance mandates, and the ten ACA mandated benefits, including prescription drug coverage. Non-grandfathered individual and small group health plan contracts and insurance policies are required to cover EHBs. [HSC §1367.005 and INS §10112.27]

3) Prohibits, with respect to an individual or group health plan contract or health insurance policy that covers EHBs, the copayment, coinsurance, or any other form of cost-sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days from exceeding $250; for a product with an actuarial value (AV) at or equivalent to a Bronze level, limits cost-sharing to not more than $500 for a supply of up to 30 days; and for a high deductible health plan (HDHP) the $250 and $500 limits apply only after the deductible requirement is met. [HSC §1342.73 and INS §10123.1932]

4) Prohibits a nongrandfathered individual or small group health plan contract or insurance policy from having an annual deductible for outpatient drugs, if any, from exceeding twice the amount specified in 3) above. [HSC §1342.73 and INS §10123.1932]

5) Requires if a health plan contract or insurance policy for a nongrandfathered individual or small group product maintains a drug formulary grouped into tiers that includes a fourth tier, the contract or policy to use the following definitions for each tier of the drug formulary:
   a) Tier one shall consist of most generic drugs and low-cost preferred brand name drugs.
   b) Tier two shall consist of nonpreferred generic drugs, preferred brand name drugs, and any other drugs recommended by the plan's or insurer's pharmacy and therapeutics committee based on safety, efficacy, and cost.
   c) Tier three shall consist of nonpreferred brand name drugs or drugs that are recommended by the pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

d) Tier four shall consist of drugs that are biologics, drugs that the Food and Drug Administration (FDA) of the United States Department of Health and Human Services (HHS) or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than $600 net of rebates for a one-month supply. [HSC §1342.73 and INS §10123.1932]

6) Permits contracts and policies to maintain a drug formulary with fewer than four tiers, but not more than four tiers. A health plan or insurer is not limited from placing any drug in a lower tier. [HSC §1342.73 and INS §10123.1932]

7) Requires every health plan contract and health insurance policy that cover hospital, medical, or surgical expenses to include coverage for equipment and supplies for the management and treatment of insulin using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription. Requires coverage for medically necessary insulin, prescriptive medications for the treatment of diabetes, and glucagon. [HSC §1367.51 and INS §10176.61]

8) Prohibits the copayments and deductibles for the benefits specified in 7) above from exceeding those established for similar benefits within the given plan. [HSC §1367.51 and INS §10176.61]

9) Requires every plan and policy to provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy that meets specified requirements including that it is provided by an appropriately licensed or registered heath care professional. [HSC §1367.51 and INS §10176.61]

10) Limits the maximum amount a health plan or health insurer can require an enrollee or insured to pay at the point of sale for a covered prescription drug to the lesser of the following:
    a) The applicable cost-sharing amount for the prescription drug; or,
    b) The retail price. [HSC §1367.47 and INS §10123.65]

11) Prohibits a health plan or health insurer from requiring a pharmacist or pharmacy to charge or collect from an enrollee or insured a cost-sharing amount that exceeds the total retail price for the prescription drug. Requires the payment rendered to constitute the applicable cost-sharing and apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the enrollee or insured had purchased the prescription drug by paying the cost-sharing amount. [HSC §1367.47 and INS §10123.65]

This bill:

1) Prohibits a health plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 2024, from imposing a copayment on an insulin prescription drug that exceeds $35 for a 30-day supply, and from imposing a deductible, coinsurance, or any other cost-sharing on an insulin prescription drug.

2) Prohibits an "HDHP," as defined in federal law, from imposing a deductible, coinsurance, or any other cost-sharing on an insulin prescription drug, unless it conflicts with federal requirements for HDHPs.

3) Requires, when the state has the capacity to label or produce an insulin prescription drug, the deductible and copayment limitations to also apply to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug, that is labeled or produced by the state.

4) Defines "insulin prescription drug" as a prescription drug product that contains insulin and is used to control blood glucose levels to treat diabetes.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, this bill prohibits health insurers and HMOs from imposing a deductible on an insulin prescription drug, or a copayment for an insulin prescription drug that exceeds $35 for a 30-day supply. This legislation comes at a critical time, as the Attorney General filed a lawsuit against the nation's largest insulin makers and pharmacy benefit managers (PBMs) for driving up the cost of the lifesaving drug through unlawful, unfair, and deceptive business practices. Additionally, Congress capped co-pays at $35 for Medicare but protections for private health plans were stripped out. While the timeline for California to begin manufacturing its own insulin is still unclear, this bill would continue to fill in this gap for many patients. This bill ensures Californians don't have to ration insulin or choose between their insulin and rent.

2) Inflation Reduction Act. According to a Data Point brief published by the U.S. HHS, Assistant Secretary for Planning and Evaluation, the federal Inflation Reduction Act of 2022 requires effective January 1, 2023, people enrolled in a Medicare Part D prescription drug plan or a Medicare Advantage plan with prescription drug coverage to have no deductible for covered insulin products and have a copayment cap of $35 per month supply of each covered insulin product. Effective July 1, 2023, Medicare Part B beneficiaries or those enrolled in a Medicare Advantage plan who use an insulin pump furnished via durable medical equipment will no longer have to pay a deductible for insulin and will have a copayment cap of $35 per month supply for their Part B covered insulin. Effective January 1, 2024, one year after the $35 cap, eligibility for the Part D Low-Income Subsidy will expand from 135% of the Federal Poverty Level (FPL) to 150% of FPL, which will allow these enrollees to further reduce their out-of-pocket costs for insulin and other medications. President Biden has included in his budget proposal to extend the cap to people with private insurance.

3) *2021 Rand report.* Key findings from "Comparing Insulin Prices in the United States to Other Countries," are below:
   a) Although the ratio of U.S. to other-country prices varied depending on the comparison country and insulin category, U.S. prices were always higher (often five to ten times higher) than those in other countries.
   b) U.S. prices were higher for analog versus human insulins in nearly all comparison countries.
   c) The overlap between the presentations of insulin sold in the U.S. and comparison countries was generally high, although there were differences in market shares across categories of insulin.
   d) The U.S. was unusual among comparison countries in permitting distribution of several types of insulin over the counter. However, U.S. manufacturer prices were still much higher than those in comparison countries even in categories in which U.S. distribution is entirely over the counter.

e) Although the authors focused their analysis on manufacturer prices rather than on net prices after potential rebates, the analysis suggests that U.S. insulin prices would still have been considerably higher, about four times higher, than those in other countries even when accounting for potential rebates.
f) For context, in 2018 the U.S. average price per standard unit of insulin was $98.70, Chile was $21.48, and Canada was $12.

4) *California manufacturing.* California has a $50 million contract with the nonprofit generic drug and pharmaceutical company, Civica Rx, to produce the three most commonly used long-acting and rapid-acting types of insulin in both vial and pen forms under a state label called CalRx. Civica was chosen to be CalRx's first manufacturing partner because of their commitment to sell insulin to all consumers at single, low transparent prices. There are two major steps when making insulin: a) manufacturing the drug substance, which is the active ingredient used to make the drug product; and, b) finishing and filling it into vials or pens. Civica is working with GeneSys Biologics to co-develop the drug substance for the three CalRx biosimilar insulins. The filling and finishing of the three insulins will be done at Civica's state-of- the-art 140,000 square-foot manufacturing plant, being built in Petersburg, Virginia. Federal approval from the FDA is expected in 2024 and the products will be available publicly shortly thereafter. Civica has announced that the manufacturer suggested prices will be the following: a) A 10mL vial will be made available for no more than $30 (normally $300); and b) A box of 5 pre-filled 3mL pens will be made available for no more than $55 (normally more than $500).

   Another $50 million will be used to support the construction of an insulin manufacturing facility based in California. CalRx plans to make biosimilar insulins available for Glargine, Aspart, and Lispro (expected to be interchangeable with Lantus, Humalog, and Novolog respectively). For CalRx, no new prescription will be needed. Californians will be able to ask for the CalRx generic at their local pharmacy or via mail order pharmacies. Pharmacies must agree to order and stock the product. Cal Rx insulin prices are estimated to be about 90% lower than list prices for branded products, saving patients between $2,000 and $4,000 annually.

5) *Voluntary price cuts.* In March 2023, Eli Lilly, Novo Nordisk, and Sanofi who make up roughly 90% of the U.S. insulin market, all announced they will cap or cut the cost of many of their insulin products. Eli Lilly announced price reductions of 70% for its most commonly prescribed insulins and an expansion of its Insulin Value Program that caps patient out-of-pocket costs at $35 or less per month. Lilly is taking these actions to make it easier to access Lilly insulin and help Americans who may have difficulty navigating a complex healthcare system that may keep them from getting affordable insulin. Novo Nordisk announced it is lowering the U.S. list prices of several insulin products by up to 75%. Products include both pre-filled pens and vials of long-acting, bolus short-acting and pre-mix insulins. Novo Nordisk is also reducing the list price of unbranded biologics to match the lowered price of each respective branded insulin. These changes will go into effect on January 1, 2024. Sanofi announced that it will cut the list price of Lantus (insulin glargine injection), its most widely prescribed insulin in the U.S., by 78%. The company also will establish a $35 cap on out-of-pocket costs for Lantus for all patients with commercial insurance. In June 2022, Sanofi also launched an unbranded Lantus biologic at 60% lower than the Lantus list price, and capped out-of-pocket costs on insulin to $35 for all people without insurance. Finally, Sanofi will also cut the list price of its short-acting Apidra (insulin glulisine injection) by 70%.

6) *California Health Benefits Review Program (CHBRP) analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:

   a) *Coverage impacts and enrollees covered*. Of the 123,442 insulin users in affected state regulated plans, CHBRP estimates 55,098 enrollees (45%) using insulin have cost-sharing that exceeds the cap in this bill.

   b) *Medical effectiveness.* CHBRP found a preponderance of evidence from seven cross-sectional and retrospective studies that cost-sharing affects insulin use and adherence in patients with diabetes. These studies provided a preponderance of evidence that higher cost-sharing reduces adherence to insulin, and lower cost-sharing increases adherence to insulin. CHBRP found insufficient evidence on the associated effect of cost-sharing for insulin on diabetes-related health outcomes, including HbA1c levels, outpatient visits, emergency department visits, hospitalizations, long-term complications, and disability/absenteeism rates overall. Though the studies presented did report on these health and utilization outcomes, the findings were not specific to the effect of insulin alone but combined with use of other oral antidiabetic medications and testing supplies. There were several limitations that contributed to the gradings provided in this review, most notably the inherent differences between the types of diabetes conditions and the multifaceted nature of diabetes treatment. This resulted in a literature base that is not as rigorous and thereby limiting the certainty of conclusions drawn from the evidence.

   c) *Utilization*. CHBRP assumes that utilization decreases by 8% when cost-sharing doubles. Based on this assumption, CHBRP estimates a 67% reduction in cost-sharing for those enrollees who have cost-sharing exceeding the cost-sharing cap at baseline, and therefore estimates a 6.6% increase in utilization of insulin for those enrollees if this bill is enacted. CHBRP notes that literature suggests approximately 2.5% of people who were prescribed insulin never started their prescription in the past year due to cost. This group is estimated to be very small.

   d) *Medi-Cal.* Medi-Cal enrollees do not have cost-sharing for insulin and are not affected by this bill.

   e) *Impact on cost-sharing*. Based on Milliman's 2021 Consolidated Health Cost Guidelines Sources Database claims data, the average cost of insulin per prescription per month is $521, the average insulin cost-sharing for over a majority of enrollees (65%) in affected state regulated plans is $13, but the average cost-sharing for those with cost-sharing that exceeds the cap in this bill is $61. Cost-sharing reductions due to this bill are the greatest for enrollees who have the highest cost-sharing for insulin in higher deductible plans. Those enrollees with cost-sharing expenditures for insulin in the top 1% at baseline would have an annual savings of greater than $1,852 if this bill were enacted. Affected enrollees with coverage purchased through Covered California would experience an average reduction in cost-sharing of $0.29 per member per month and an increase in premiums of $0.51 per member per month (for all enrollees). This results in a

total change in expenditures of 0.03%.

f) *Impact on expenditures*. Total health insurance premiums paid by employers, employees, and individuals/families, including people who receive reduced cost-sharing under this bill will experience an estimated increase of $62,458,000. Changes in premiums vary by market segment. The greatest change in premiums as a result of this bill is for small-group (0.10% increase) and individual (0.08% increase) plans in the DMHC-regulated market and small-group (0.09% increase) and individual (0.08% increase) in the CDI-regulated market. Total cost-sharing for affected enrollees will decrease an estimated $32,430,000. CHBRP assumes a 10% decrease in diabetes-related emergency department visits due to increased insulin utilization stemming from better adherence to insulin prescription regimens for those who underuse. Offsets stemming from this reduction in diabetes-related emergency department visits are estimated to result in $2,495,000 lower allowed costs post mandate in 2024.

g) *CalPERS.* There are no CalPERS enrollees for whom cost-sharing for insulin prescriptions is higher than the cap under this bill, so premium impact for CalPERS enrollees is zero.

h) *Public health.* This bill may result in improved glycemic control, a reduction in healthcare utilization such as emergency department visits, a reduction in long-term complications attributable to diabetes, and improved quality of life for enrollees that experience a decrease in cost-sharing and improved insulin adherence or begin using insulin due to reduced costs. CHBRP estimates that this bill would improve disparities related to income for some enrollees who have cost-related barriers to insulin use. CHBRP is unable to estimate reductions in existing disparities. However, because the prevalence of diabetes is higher for Black people than for White people, and there is evidence that cost-related medication nonadherence is also higher among Black people, it is possible that this disparity may be reduced for the population this bill impacts. Because of the lack of evidence that reduced cost-sharing for insulin reduces mortality, the impact of this bill on premature mortality is unknown. However, well-controlled blood glucose results in fewer diabetes-related comorbidities (blindness, amputations, kidney disease, etc.). Therefore, for those patients who attain good glycemic control through increased adherence to insulin, these diabetes-related comorbidities that are known to lead to premature death could be prevented, delayed, or ameliorated.

i) *EHBs*. CHBRP indicates this bill does not exceed the definition of EHBs which means the state would not have to defray federal subsidy costs for individuals who qualify for federal premium tax credits through Covered California.

7) *Covered California Standard Plan Designs.* Covered California is California's state based marketplace (or exchange), which was created as a result of the federal ACA. Covered California makes health insurance plans available to purchase for individuals (and families) and small employers. Qualified individuals can also get financial assistance when purchasing individual/family policies through Covered California. State and federal law require plans sold in the individual and small group market to meet 90/80/70/60% AV requirements. This means that a platinum plan with 90% AV requires the plan to pay on average 90% of the cost of covered benefits and the enrollee pays 10% in the form of cost-sharing. These tend to be higher cost premium plans with the lowest cost-sharing requirements. On the other end, a bronze plan has a 60% AV which means the plan pays on average 60% of costs of covered

benefits and the enrollee pays 40% in the form of cost-sharing. Bronze are typically the lowest cost premium plans but have the highest enrollee cost-sharing. There is some room allowance, referred to as de minimis range, which allows designs to fall a little outside the AV ranges but beyond that the products that fall outside of the AV requirements cannot be sold.

Covered California indicates that legislation, such as this bill, that limits cost-sharing for specific drugs or medical services could impact Covered California's ability to set standard benefit designs, which also impact individual and small group products offered outside of Covered California. *Reducing the cost-sharing for one benefit could result in higher cost-sharing for other benefits.* To illustrate how this works using the Silver 70 AV product from 2023, when the exact same plan design was run through the 2024 AV calculator (a federal instrument that is updated annually to reflect medical, pharmacy, and other trends), Covered California, with the consultation of their plan management advisory committee, decided on the following cost-sharing requirements for 2024:

a) Increased medical deductible by $650 (from $4750 to $5400)
b) Increased drug deductibles by $65 (from $85 to $150)
c) Increased maximum out of pocket by $350 (from $8,750 to $9,100)
d) Increased emergency room copay by $50 (from $400 to $450)
e) Increased copays by $5 for the following services: primary care, mental health and substance use disorder services, speech therapy, occupational and physical therapy, and specialist visits
f) Increased Tier 1 generic drugs by $3 (from $16 to $19) with no deductible
g) Increased outpatient coinsurance to 30% for outpatient facility/physician fees

Covered California conducted an analysis of a substantially similar bill, SB 473 (Bates of 2022), and analyzed a $35 cap on insulin drugs listed under the Tier 2 category of "preferred drugs." Based on 2022 plan designs, capping Tier 2 insulin drugs alone would have rendered Covered California's bronze plans out of compliance with federal and state laws pertaining to AV, requiring cost-sharing adjustments to be made in other benefit categories. This bill applies a $35 cap to *all* insulin drugs, which would put additional pressure on Covered California's ability to offer products consistent with federal AV requirements. As such, Covered California recommends narrowing the $35 cap to insulin drugs listed in Tier 1 and Tier 2 for the individual and small group markets (to exclude "non-preferred," more costly drugs commonly listed in Tiers 3 and 4 of drug formularies). This tailored approach coupled with a delayed implementation to 2025 for the individual and small group market limits the AV impact and allows Covered California to prospectively build the $35 limitation for Tier 1 and Tier 2 insulin into the following year's standard benefit design.

8) *Attorney General action.* In January 2023, California Attorney General Rob Bonta announced a lawsuit against the nation's largest insulin makers (Eli Lilly, Novo Nordisk, and Sanofi) and three PBMs (CVS Caremark, Express Scripts, and Optum Rx) for driving up the cost of insulin through unlawful, unfair, and deceptive business practices in violation of California's Unfair Competition Law. The lawsuit alleges these manufacturers and PBMs have leveraged their market power to overcharge patients. The complaint alleges the defendants separately conspired to artificially inflate prices while agreeing to provide secret rebates in an attempt to obtain preferred positions on drug formularies.

9) *Prior legislation.* SB 473 (Bates of 2022) would have required a health plan or insurance policy to cover all available dosage forms and concentrations of insulin for a copayment of no more than $35 for a monthly supply. *SB 473 was held in the Assembly Appropriations Committee.*

   AB 97 (Nazarian of 2021) would have prohibited a health plan contract or disability insurance policy from imposing a deductible on an insulin prescription drug. *AB 97 was held in the Senate Appropriations Committee.*

   SB 852 (Pan, Chapter 207, Statutes of 2020) requires the California Health and Human Services Agency to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and, to increase patient access to affordable drugs. Included in SB 852 is that partnerships include the production of at least one form of insulin, provided that a viable pathway for manufacturing a more affordable form of insulin exists.

   AB 2203 (Nazarian of 2020) would have established a copayment cap for insulin and prohibited a health plan contract or a health insurance policy from imposing cost-sharing on a covered insulin prescription, except for a copayment not to exceed $50 per 30-day supply of insulin, and no more than $100 total per month, regardless of the amount or type of insulin. AB 2203 would have authorized the Attorney General to investigate pricing of prescription insulin drugs made available to California consumers, considering the role of each entity in the entire supply chain, to ensure adequate consumer protections in pricing of prescription insulin drugs and determine whether additional consumer protections are needed, as specified. *Due to the shortened Legislative calendar brought on by the COVID-19 pandemic, AB 2203 was not set for a hearing in the Senate Health Committee.*

10) *Support.* The American Diabetes Association (ADA) writes that according to the Centers for Disease Control and Prevention more than three million, or 10.2% of California's adult populations, has been diagnosed with diabetes. The prevalence increases with age—one out of every six adult Californians aged 65 and above have type two diabetes—and this rate is higher among ethnic/racial minorities and Californians with low family income. A 2018 ADA patient survey confirmed that many individuals who face high out-of-pocket costs for insulin are not adhering to their diabetes care plan- and are instead rationing insulin for financial reasons. Insulin is essential to maintaining appropriate blood glucose levels and reducing the risk of serious complications such as cardiovascular disease, blindness, amputation of the lower extremities, kidney disease and death. When insulin is not taken appropriately, the risk of serious complications and death increases quickly. In 2018, the average annual healthcare deductible was $1,402 for single and $2,706 for family coverage. This bill would prohibit HMOs and insurance companies from requiring Californians to spend thousands of dollars on their deductible before being able to access their copay for insulin. The California Black Health Network (CBHN) writes that according to the HHS Office of Minority Health, 13.4% of Black men and 12.7% of Black women have been diagnosed with diabetes. Blacks are twice as likely to develop type two diabetes as Whites. They are twice as likely as non-Hispanic Whites to die from diabetes. Californians with diabetes rely on daily doses of insulin for survival. Without access to insulin, patients can develop serious health complications, including cardiovascular disease, blindness, and kidney disease. CBHN writes this bill will protect patient health and safety by ensuring affordable access to insulin for those who depend on it for survival, and it is a critical step forward

toward making insulin affordable for all and save more lives. Health Access California writes prescription drug costs are too high, which has serious consequences for consumers' ability to afford their medications and their health. For insulin, the price hikes are especially outrageous because the innovators behind insulin donated the patent a century ago as a life-saving drug for those with diabetes. Despite this, in the last few decades, insulin price hikes have driven up costs for consumers, moving from the modest costs for generic drugs to prices that often lead to insulin being on the highest cost tier for prescription drugs. A vial of insulin that costs $21 in 1999 costs $332 per vial as of 2019. Even those with coverage end up paying a lot in cost-sharing as a result.

11) *Opposition.* The Association of California Life and Health Insurance Companies (ACLHIC) and the California Association of Health Plans (CAHP) write that concern over affordability is further underscored in the CHBRP report, as it projects premiums to rise by approximately $62 million. Changing prescription drug benefits in this manner makes it difficult for plans and insurers to meet their statutorily required AV percentages, especially in bronze plans. If a mandated reduction in cost-sharing impacts the AV, plans and insurers may be forced to increase other cost-sharing components in order to keep the overall benefit design within the required AV limits. The opponents ask if the supporters of this bill are prepared to tell policymakers which services should see an increase in out-of-pocket costs if this bill is implemented. Currently, prescription drugs are the second highest expense incurred by health plans and insurers. Given the recent news about pharmaceutical companies promising to lower their decade's long rampant price increases, there is further evidence that big pharma companies alone control the underlying price of their products. Previous to these most recent announcements we had seen non-stop price hikes by the drug companies, including a 55% average rise in the cost of insulin since 2014 with no end in sight. The increase far outpaced inflation, without any major medical improvements to the drug. This bill mandating a specific limit on the cost-sharing of a very specific piece of the overall health benefit plan will not achieve the goal of affordable or sustainable healthcare for all. Instead, this bill should focus on drug companies lowering their prices and hold them accountable for driving up the cost of the drug and driving up premium costs for all Californians. The California Chamber of Commerce writes Governor Newsom recently announced that CalRx has secured a contract with Civica to make $30 insulin available to Californians. This process should be seen to fruition prior to implementing a coverage mandate. When looking at the coverage mandate cost increases in isolation they seem tolerable, however, this bill must be considered in context. Premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2022 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 20% over the last five years and 43% over the last 10 years. Additionally, for job-based coverage, the average annual premium for single coverage was $7,911. On average, covered workers contribute 17% of the premium for single coverage and 28% of the premium for family coverage. California should not increase health care coverage costs for employers and employees with another mandate.

12) *Policy comments.* This is one out of at least four Senate Bills with cost-sharing limitations that the committee will be hearing, and there are at least seven Assembly Bills. Each bill on its own may or may not impact AV issues but together, there most definitely is an impact. As Covered California indicates, there are tradeoffs that come with bills that impose cost-sharing restrictions. Specifically, other equally important services may have higher cost-sharing requirements applied to offset the impacts of these bills. Policymakers should understand and be comfortable with these tradeoffs as these bills are being evaluated. Covered California has

provided technical assistance amendments related to this bill to minimize the impacts, which Committee members may wish to consider. The author has agreed to take the amendments suggested by Covered California.

13) *Amendments.*

a) It is not clear why this bill subject's drugs or therapeutic equivalents labeled or produced by the state to the requirements of this bill. If those drugs or therapeutics are covered by a plan they would be subject to this bill so this provision seems unnecessary.

b) The technical assistance suggested by Covered California includes the following amendments in both the Health and Safety and Insurance Codes:

(d) (1) Notwithstanding subdivision (c), a health care service plan contract that is issued, amended, or renewed on or after January 1, 2024, ***or for contracts offered in the individual or small group market on or after January 1, 2025,*** shall not impose a copayment on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply, and shall not impose a deductible, coinsurance, or any other cost sharing on an insulin prescription drug.
(2) If a health care service plan contract for an individual or small group product maintains a drug formulary grouped into tiers, the copayment of not more than thirty-five dollars ($35) for a 30-day supply, pursuant to subdivision (d)(1), shall apply only to insulin prescription drugs that are in Tier 1 and Tier 2.

SUPPORT AND OPPOSITION:

Support: American Diabetes Association (sponsor)
AARP
AFSCME
American College of Obstetricians and Gynecologists District IX
Association of Regional Center Agencies
Biocom California
California Alliance for Retired Americans
California Association for Health Services At Home
California Black Health Network
California Chronic Care Coalition
California Podiatric Medical Association
California State Council of Service Employees International Union
City of Long Beach
Cystic Fibrosis Foundation
Health Access California
Indivisible CA StateStrong
San Francisco Marin Medical Society
UCLA Chapter of Universities Allied Essential Medicine
Six individuals

Oppose: America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

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